SmilesNY

Today's Date: _______________

Patient's Name	**Date of Birth**	**OFFICIAL USE ONLY**
Physician's Name and Address		Pre-Med Yes ❒ No ❒
Physician's Phone		Comments:
Date of your most recent visit to Physician	Reason	
How would you assess your general Health? ❒ Good ❒ Fair ❒ Poor		

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition?	❒	❒
2. Have you been hospitalized within the last year? If yes, explain:	❒	❒
3. Have you had a serious illness or operation within the last year? If yes, explain:	❒	❒
4. Have you ever had any serious medical trouble associated with any dental experience? If yes, explain:	❒	❒
5. Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:	❒	❒

Do you now or have you had any of the following diseases or problems?

Cardiovascular Disease .... ❒ ❒

If yes, check any that apply:

- ❒ heart disease
- ❒ heart attack
- ❒ coronary bypass
- ❒ angina
- ❒ mitral valve prolapse
- ❒ hardening of the arteries
- ❒ high blood pressure
- ❒ stroke
- ❒ heart murmur
- ❒ congestive heart failure

	Yes	No
Rheumatic fever or rheumatic heart disease	❒	❒
Congenital heart defects	❒	❒
Prosthetic (artificial) heart valves	❒	❒
Pacemaker? If yes, date of placement ________	❒	❒
High blood pressure	❒	❒
High cholesterol	❒	❒
Are you short of breath after mild exercise?	❒	❒
Do your ankles swell?	❒	❒
Do you get short of breath when you lie down?	❒	❒
Do you have chest pain upon exertion?	❒	❒
Abnormal bleeding or extended clotting time	❒	❒
Frequent or unexpected nose bleeds	❒	❒

Diabetes ? .... ❒ ❒

If yes, do you require insulin? ❒ ❒

Type and Dose

____

Do you have an artificial joint? .... ❒ ❒

If yes, which joint(s)?

____

Hepatitis ? .... ❒ ❒

If yes, check type:

- ❒Type A
- ❒Type B
- ❒Type C
- ❒Other
- ❒Non-Specific Type
- ❒Don't know

Have you ever required a blood transfusion? ❒ ❒

If yes, what was the date of the transfusion?

____

Are you HIV positive?	❒	❒
Do you have any reason to suspect that you have been exposed to the HIV virus	❒	❒
Have you ever had Tuberculosis (TB)?	❒	❒
Have you ever had a TB test?	❒	❒
Do you have a cough that has lasted more than 3 weeks?	❒	❒
Do you ever cough up blood?	❒	❒

CHECK ANY THAT APPLY:

- ❒Allergies
- ❒Alzheimer's Disease
- ❒Anemia
- ❒Angina
- ❒Asthma
- ❒Arthritis
- ❒Autoimmune Disease
- ❒Blood Disorder
- ❒Cancer
- ❒Chemo Therapy
- ❒Radiation Treatment
- ❒Respiratory Problems
- ❒Cirrhosis
- ❒Depression
- ❒ Diabetes
- ❒Drug or Alcohol Treatment
- ❒Epilepsy or other seizures
- ❒ Glaucoma
- ❒ Heart Disease
- ❒ Herpes
- ❒ HIV / AIDS
- ❒ Jaundice or Liver Disease
- ❒ Joint Replacement
- ❒ Kidney Disease
- ❒ Organ Transplant
- ❒ Osteoporosis
- ❒ Parkinson's Disease
- ❒ Sinus Problems
- ❒ Serious/Frequent Headaches
- ❒ Sexually Transmitted Disease
- ❒ Skin Problems
- ❒ Tuberculosis
- ❒ Ulcers
- ❒ Other_________

(OVER)

	Yes	No
Do you consider yourself currently under an abnormally high amount of stress?	❒	❒
Have you had any unexplained or unplanned Weight loss?	❒	❒
Do you now or have you ever smoked? (Please circle) Cigarettes Pipe Cigar Other If you currently smoke, how much?__________ If you have smoked in the past but no longer smoke, when did you quit? ____________	❒	❒
Do you chew tobacco? If yes, how often? __________________	❒	❒
Do you drink alcohol? If yes, how often? __________________	❒	❒

WOMEN:

Are you currently pregnant? Expected delivery date ______________	❒	❒

If you are currently taking any medications, or if you have taken any medications within the past year, please list:

Are you ALLERGIC to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):

- ❒ Antibiotics (penicillin, tetracycline, etc .)
- ❒ Local Dental Anesthetics (novacaine)
- ❒ Codeine
- ❒ Aspirin
- ❒ Barbiturates or Sedatives
- ❒ Tranquilizers
- ❒ Others

____

	Yes	No
Have you ever had an adverse reaction like nausea, dizziness, or feeling "spacey" with any drug or medication?	❒	❒
Do you have any disease, condition or problem not previously listed that you feel we should know about?	❒	❒

Important Policies

Commitment to Appointment Policy – We reserve time for each patient in our practice and rarely do we ever keep our patients waiting. As appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and you will be present for that appointment. We do not allow cancellations or short-notice changes. **We require at least 48 hours advance notice for all changes in schedule.** Your signature below indicates that we must have mutual respect for each other's time.

I acknowledge that payment in full is due at the time of treatment, unless other arrangements are contracted in advance.

Signature:

____

Name & Signature below of person responsible for the account is different than the listed patient.

____

Today's Date ______________

I authorize **SmilesNY - FishmanRothChase, LLP** to keep my signature on file and to charge my Credit Card for all visits, unpaid balances, and recurring charges for on-going treatments. All unpaid balances over 45 days are subject to 18% finance charge. The finance charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18%.

Signature: ______________________________

Print Name: ______________________________

Acct#___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Exp: __________ Security Code: _____